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This brief is a collaboration between the Georgetown University Center for Children and Families and the Children's Dental Health Project. It presents an overview of some of the key changes the Affordable Care Act makes to children's dental benefits and the choices states face in defining pediatric dental benefits.

PEDIATRIC DENTAL BENEFITS UNDER THE ACA: ISSUES FOR STATE ADVOCATES TO CONSIDER

by Meg Booth, Colin Reusch and Joe Touschner

The Affordable Care Act (ACA) makes a number of important improvements intended to increase access to dental coverage for children who get health coverage in the individual and small group health insurance markets, including those who will be covered through the new health insurance exchanges. Since the specific benefits in these markets will be determined at the state level, state advocates have an opportunity to help shape children's dental benefits and ensure that dental plans provide adequate coverage. Pediatric dental benefits are critical for children's overall health and the ACA includes substantial changes in the way they will be provided for many kids, so the coming months represent a important chance to improve outcomes for children. This brief provides background on the state role in implementing the ACA's changes to pediatric dental benefits and makes recommendations for how advocates can engage to improve children's oral health.

How do children receive dental coverage today?

Pediatric dental benefits vary considerably between private dental plans and public health coverage delivered through Medicaid and the Children's Health Insurance Program (CHIP). While dental coverage in the private market is often marked by strict dollar limits on benefits, public programs often deliver care in a more comprehensive manner, focusing on the services necessary to effectively prevent and treat dental disease.

Most commonly, private dental coverage is provided through employer-sponsored benefit plans separate from those that provide medical coverage. While 68 percent of very large employers (500 or more employees) offer dental coverage, dental benefits are less frequently available to dependents of small business employees—only 26 percent of small employers (1-49 workers) offer dental benefits. And very few dental benefit plans are purchased on the individual market—only about one percent of dental benefits are accessed this way.[1]

While this coverage is commonly referred to as dental insurance, it is more appropriately considered a limited prepayment plan rather than a true risk-sharing insurance program. Such plans generally have a low premium for workers and require minimal contribution on the part of em-

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ployers. Beneficiaries are eligible for a significantly limited range of low-cost preventive and diagnostic services while they often incur high out-of-pocket costs for other procedures. Unlike medical insurance, which usually pays for services within the plan limits when they are covered benefits and determined to be medically necessary, dental plans are built around relatively low annual dollar limits on coverage. The average annual maximum benefit for employer-sponsored dental policies is about $1,500.[2]

The ACA addresses some of the traditional barriers families face with regard to private dental coverage for children covered in the individual and small group health insurance markets.

On the other hand, dental services provided to children through state Medicaid programs are intended to be more comprehensive. Medicaid is required to meet the standards of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), which is designed to ensure that children receive all services deemed appropriate and necessary by a provider.[3] While Medicaid dental benefits are often administered through contracts with private dental plans, all enrolled children are entitled to receive medically necessary services according to the dental periodicity schedule that each state is required to have in place.[4] Despite these legal guarantees, many states exhibit low rates of dental visits by children in Medicaid.[5]

In states that administer CHIP separately from Medicaid, federal law allows states to design dental benefits for children differently. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) established a new statutory definition of CHIP dental benefits as "…dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions."[6] Previously, the inclusion of pediatric dental coverage was an option for state CHIP programs and while every state had voluntarily chosen to implement some form of pediatric dental benefit, CHIPRA made this a requirement.

States with separate CHIP programs vary in their provision of dental benefits, with some mirroring private dental plans with dollar limits and others that place fewer costs on beneficiaries' families. While federal guidance identifies nine categories of dental procedures that CHIP must cover,[7] regulations to provide greater specifics of the CHIP dental benefit have yet to be released and only a small number of states have submitted a state plan amendment (SPA) to update their benefit in response to CHIPRA. Among the states whose SPAs have been approved by the Centers for Medicare and Medicaid Services, there is considerable variation not only in the degree to which services are covered but also in the level of cost-sharing for beneficiaries.[8] As a result, some advocates are calling for more specific federal guidance to states on the comprehensiveness of dental benefits and how families' out-of-pocket expenses should be tracked across medical and dental expenditures.[9]

In addition, CHIPRA gives states the option to use CHIP to provide supplemental dental benefits to income-eligible children who have private health coverage. Prior to CHIPRA, having private coverage would make a child ineligible for any CHIP benefits. But by adopting this CHIPRA option, states can use CHIP to "wrap-around" a family's private coverage and provide dental benefits that may be lacking in the family's plan. Currently, Iowa is the only state to have adopted this option.

How does the ACA change children's access to dental coverage?

Children who receive dental benefits through plans sponsored by large employers as well as Medicaid and CHIP will keep the coverage they currently have as the ACA is implemented. For other children, the ACA addresses some of the traditional barriers families face with regard to private pediatric dental coverage in the individual and small group health insurance markets. See Figure 1 for a schematic of how children will access dental benefits in 2014.

For the individual and small group private insurance markets, a minimum set of benefits known as the essential health benefits (EHB) will be

available in 2014. The ACA requires that pediatric dental benefits (along with other pediatric services) be part of the EHB. In addition, for all plans in the exchange, the ACA prohibits the use of annual dollar limits, a significant change from current practice.

While medical plans have the option of providing a bundled benefit that includes pediatric dental coverage in exchanges, dental benefits may continue to be offered in a plan separate from other health care benefits. If a separate pediatric dental plan is offered in an exchange, individual and small group exchange plans do not have to offer pediatric dental benefits themselves. But if no separate pediatric dental plans are offered, then all exchange plans must offer these benefits to fulfill the EHB requirement.

Final exchange rules from HHS stipulate that pediatric dental benefits cannot be subject to annual or lifetime dollar limits.[10] This will require plans offering dental benefits in the exchange to structure them differently than most existing private dental coverage. It is, however, unclear what strategies most dental plans will employ in order to adhere to the regulations while at the same time managing plans' risk. Dental plans may be able to adjust by providing a more robust pediatric benefit through the implementation of evidence-based and preventive practices that focus care on a child's level of risk for disease while eliminating unnecessary procedures that are often costly. Clinical guidelines for this approach to dental care are supported by the American Academy of Pediatric Dentistry, as well as the American Academy of Pediatrics. These guidelines have also been endorsed by 42 of the nation's dental school deans[11] and in a joint letter from more than 50 child health organizations and dental coverage plans.[12]

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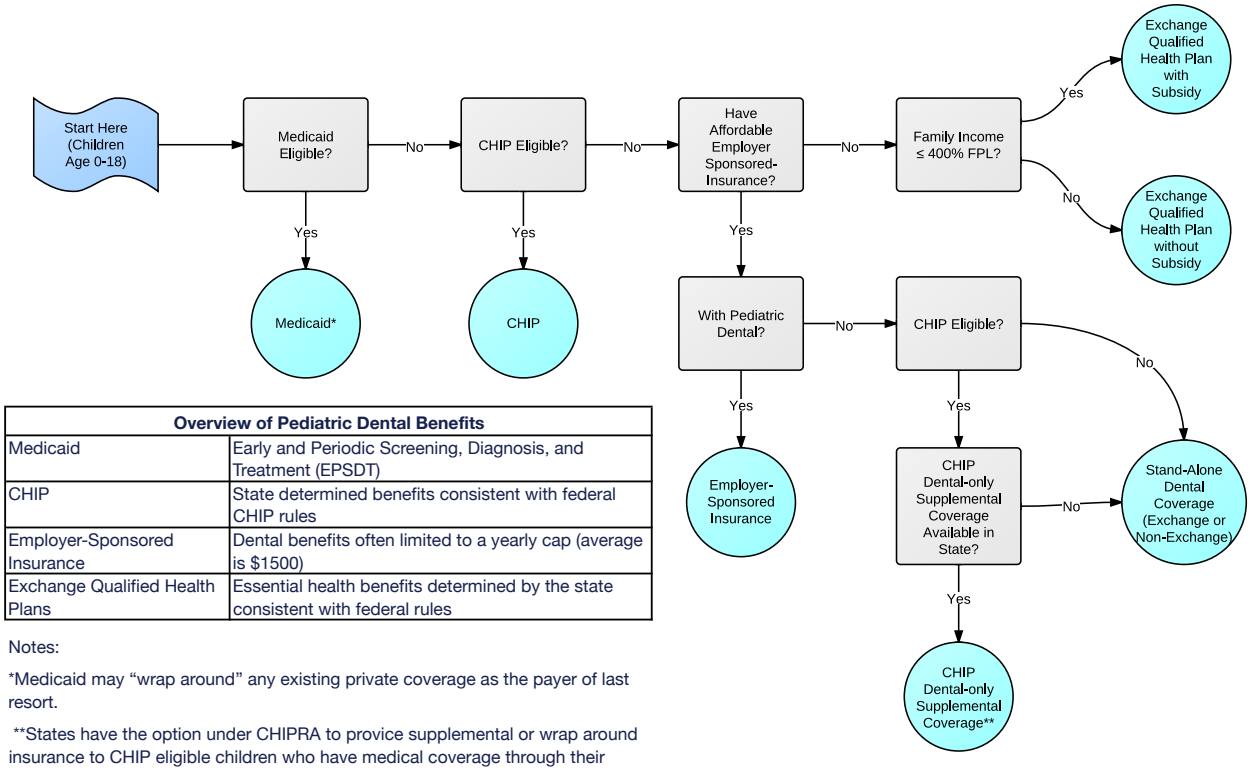
Figure 1: How will children access dental benefits in 2014?



Overview of Pediatric Dental Benefits	
Medicaid	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
CHIP	State determined benefits consistent with federal CHIP rules
Employer-Sponsored Insurance	Dental benefits often limited to a yearly cap (average is $1500)
Exchange Qualified Health Plans	Essential health benefits determined by the state consistent with federal rules

Notes:

*Medicaid may "wrap around" any existing private coverage as the payer of last resort.

**States have the option under CHIPRA to provice supplemental or wrap around insurance to CHIP eligible children who have medical coverage through their parents but no dental insurance.

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What are the choices for states?

States will choose their EHB largely by reference to the benefits in an existing employer-sponsored plan. States may choose from among the largest small group plans, state employee plans, federal employee plans, or the largest HMO in the state. If any of the ACA-required benefit categories such as pediatric oral health services are missing from that "benchmark" plan, they must add the missing benefits.[13]

Since states' benchmark choices are medical plans, many of them do not provide coverage for dental services for children. Thus, pediatric dental benefits are likely to be among the missing benefits. HHS has provided guidance on supplementing a benchmark plan that lacks pediatric dental benefits: States can choose to add the pediatric dental benefits from either the federal employees supplemental dental plan or from the state's separate CHIP program. If the state does not have a separate CHIP plan, it may define a dental benefit consistent with CHIP requirements for the purpose of adding pediatric dental benefits to its EHB.[14]

Child advocates can help their states choose the most appropriate pediatric dental benefit. The recommendations below suggest some avenues for engaging in your state's choice.

Recommendations

A key first step in advocacy around dental benefits for children is to raise the importance of pediatric dental benefits among decision makers. With the myriad issues state and federal decision makers must address regarding implementation of the ACA and the establishment of health insurance exchanges, dental-specific issues for children can easily be left unattended. Advocates should work to ensure that pediatric oral health services are not an afterthought when states choose their EHB, develop rules for insurance plans, and make adjustments to Medicaid and CHIP in response to the ACA. Additional recommendations include:

1. **Carefully examine your state's dental benefit benchmarks with particular attention to the CHIP dental benefit:** Many potential benchmark plans do not include pediatric only dental benefits. Additionally, significant variation exists between CHIP, state employee health plans, and the federal employees supplemental dental coverage. Since HHS has pointed to the federal employees plan and CHIP as the potential choices for states when the benchmark plan lacks pediatric dental benefits, comparisons among benchmark choices should start with these. Is your state's CHIP dental benefit preferable to the largest federal plan, the FEDVIP MetLife High option? A link to the FEDVIP MetLife benefits is below, while CHIP dental benefits may be available from your state's CHIP agency or state CHIP plan. Advocates should convene the dental, medical, and consumer communities to identify the benchmark plan that best meets children's needs with regard to comprehensiveness, with a focus on preventive services, including fluoride treatments and dental sealants, as well as the coverage of medically necessary orthodontic care. Such benefits should ideally place emphasis on early intervention, risk assessment, and preventive care across provider types.

2. **Explore alliances with insurers who may offer coverage in the individual and small group markets:** Many benefit companies are currently in the process of determining whether they will offer coverage inside and outside of the exchanges and are working to develop benefits to meet the EHB standards. State advocates should engage dental benefit companies to offer their expertise in identifying appropriate benefits and ask for robust pediatric dental benefits that truly meet the needs of children with regard to affordability, prevention, and medical necessity. New, innovative benefit models that

incentivize prevention and outline treatment plans according to each child's level of risk for disease are not commonly in practice in the private dental plan market. Some insurers, however, have expressed interest in providing new models of care that allow them to provide a cost-effective benefit without annual and lifetime caps. The desire of state advocates and policymakers to find common ground on cost-effective approaches to comprehensive dental care could serve as the catalyst for institutionalizing new models of care and financing. For more information, see the Consensus Statement linked below under Structuring the Pediatric Dental Benefit or contact the Children's Dental Health Project.

3. **Emphasize the importance of network adequacy when choosing benefit plans:** Federal regulations require health insurance exchanges to ensure that all participating dental benefit plans have a provider network that is adequate to serve all children who may be covered. Advocates should encourage exchange officials to develop specific network adequacy standards to which dental plans can be held. While there are currently no consistent national standards for network adequacy with regard to dental benefits, each state does have a similar standard for Medicaid benefits that may serve as a starting point.

4. **Carefully monitor implementation and share experiences with other states:** Advocates should work together to monitor the long-term implementation of the EHB with a focus on the delivery of high-quality and affordable dental benefits for children. One area of specific concern is the mechanism by which families' out-of-pocket expenses will be tracked across medical and dental plans, to the extent they are offered by separate issuers. Additionally, the federal government has indicated that it plans to review the appropriateness of its benchmark approach to the EHB and determine if modifications are necessary before 2016. Careful tracking could help identify potential shortcomings of the approach that would be appropriate for federal review.

5. **Consider advocating for your state to adopt the CHIPRA option to provide wrap-around dental benefits:** The ACA will improve access to dental benefits for children covered in the individual and small group markets. But large employer plans are not required to offer the essential health benefits with their pediatric dental component. One way to boost access to dental benefits for low- and moderate-income children who get coverage in the large group market is for states to adopt this relatively new option. The option is available for states with separate CHIP programs that meet certain requirements. For more details, see the link under Additional Resources below.

Additional Resources

CHIP Dental Benefits

- CHIP Dental Coverage: An Examination of State Oral Health Benefit Changes as a Result of CHIPRA
- Making CHIP Work for Kids: Changes in State CHIP Dental Coverage Subsequent to CHIPRA

Essential Health Benefits

- Child Health Advocates Guide to Essential Health Benefits

Federal Employee Dental Benefit

- Info on FEDVIP MetLife Dental Benefit

Structuring the Pediatric Dental Benefit

- Consensus Statement on Pediatric Dental Benefits organized by the Children's Dental Health Project

Supplemental Dental Benefits through CHIP

- Access to Child-Only Supplemental Dental Coverage through CHIPRA: A Handbook for Advocates and Policymakers

Endnotes

1. U.S. Department of Labor, Bureau of Labor Statistics, "Health Care Benefits: Access, Participation, and Take-up Rates, Civilian Workers" (March 2011).
2. National Association of Dental Plans & Delta Dental Plans Association. "Offering Dental Benefits in the Health Exchanges: A Roadmap for Federal and State Policymakers" (September 2011).
3. See Federal Register at 42 CFR 441.56.
4. D. Schneider & J. Crall, "EPSDT Periodicity Schedules and Their Relation to Pediatric Oral Health Standards in Head Start and Early Head Start", National Oral Health Policy Center (June 2005).
5. R. Hakim, J. Babish, & A. Davis, "State of Dental Care Among Medicaid-Enrolled Children in the United States," Pediatrics, 130(1): 1-10 (June 2012).
6. "Children's Health Insurance Program Reauthorization Act of 2009," Pub. L. 111-3, 123 Stat 8, Section 501 (2009).
7. Letter from Cindy Mann, Director Center for Medicaid and State Operations at the Centers for Medicare and Medicaid Services to State Health Officials (SHO #09-012), (October 7, 2009).
8. National Maternal and Child Oral Health Policy Center, "CHIP Dental Coverage: An Examination of State Oral Health Benefit changes as a Result of CHIPRA" (December 2011).
9. Children's Dental Health Project, "Making CHIP Work for Kids: Changes in State CHIP Dental Coverage Subsequent to CHIPRA" (March 2012).
10. See Federal Register at 45 CFR 155.1065.
11. Letter from the U.S. Dental School Deans to Secretary Sebelius, (September 2011).
12. Letter from Children's Health Groups and Delta Dental Affiliates, (September 2011).
13. See J. Touschner, "Child Health Advocates' Guide to Essential Health Benefits," Georgetown University Center for Children and Families (August 2012) for more information on how states will select their EHB.
14. Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin" (December 2011).

Authors: Meg Booth is Director of Policy and Colin Reusch serves as Policy Analyst for the Children's Dental Health Project. The Children's Dental Health Project is a national non-profit organization with the vision of achieving equity in children's oral health.

Joe Touschner is a Senior Health Policy Analyst with the Georgetown University Center for Children and Families.

The Center for Children and Families (CCF) is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. CCF is based at Georgetown University's Health Policy Institute. For additional information, contact (202) 687-0880 or childhealth@georgetown.edu.